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EARLY SCREENING

MEDICAID IS FINDING AND TREATING THE HEALTH PROBLEMS OF CHILDREN IN ELIGIBLE LOW-INCOME FAMILIES.

HUMAN NEEDS
Vol. 1, Nos. 4-5/Oct.-Nov. 1972

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Cover Notes

In the landscape of violence, there is no peace—of mind, of form, or of habit. The turbulence of our scarred cities is everywhere evident. And in the jagged shadows of shredded neighborhoods grow the children who should be the new builders of tomorrow.

It is not fair to ask the next generation to build new and to build strong, when the present generation tolerates decay and disintegration. When grass grows through the open concrete floors of homes long gone, children learn the transience of the environment. The homes. The grass. The daylight and darkness. The children themselves. All can pass without notice.

But such lessons make children the accomplished agents of despair. Weeds and trash become their tools, the toys of a dismembered community. We have offered rubble—broken ideas, damaged commitments, discolored compassion—to youth and we tend to punish any response that is not a display of thankfulness. When we are repaid in trash, our generation in control, we adults, we leaders, are offended.

To the children playing in the rubble of our cover, in the neighborhood of despair, society owes a promise: that warm words of reason will banish the chill of fear, that deeds of compassion will resurrect hope, that the intricate engines of our industrial society will be used to rebuild the simple places of home and family, the innocent places, the good places that, together, produce not just a nation but a civilization.

Government—those who govern and those who give their consent—is judged by children who live in the wreckage of the old good places. Their judgment is swift and lasting, if society fails to redress the basic grievance: despair.

—T.O.C.

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State and local welfare agencies may buy services from private organizations under the terms of the Social Security Act.

Getting flexibility with

Purchases of Service

ROBERT B. DOHERTY. In 1971 the Saginaw County (Michigan) Department of Social Services realized they were not geared to supply all the social services needed by the people of that County. Personnel of the Department were concerned over the gap between needs and resources. They sent out a call for help.

The Department contacted the Saginaw Volunteer Bureau (since known as the Voluntary Action Center). The Department asked the Bureau for help in recruiting and orienting volunteers who would then provide a range of services—from tutoring to family assistance—that were either absent or inadequate.

To get the new program under way, the Saginaw County Department of Social Services created the position of Coordinator of Volunteer Services, funded as part of the evolving volunteer program. Ms. Susan Topliff was chosen for the position. Ms. Topliff worked closely with Ms. Dorothy Rappa, Executive Director of the private Volunteer Bureau, in the design, development, and implementation of the new program.

The Department purchased the services of the private Saginaw County Volunteer Bureau under the 75 percent-25 percent matched funding provided under the Social Security Act, as amended in 1967. The County Board of Commissioner and the Council of Churches together

raised the local 25 percent; the Federal Government funneled in the matching 75 percent. On January 28, 1972, the Saginaw County volunteer program was officially begun with a kitty of $13,860. And the needy citizens of the County began to receive more and improved social service.

This is not an unusual story in Michigan, where similar programs using volunteers have sprung up. One reason is certainly the leadership of Ms. Elizabeth Frier, State Administrator of Volunteer Services. But another reason for success here—and in many other areas of the country—is the legal authority to purchase those services that local government cannot provide on a continuous, ongoing basis.

The language of the Social Security Act, as amended, created the potential for this mechanism, popularly known as the "purchase of services" arrangement. Title IV-A, Section 406 (a) provides for "services to a family or any member thereof for the purpose of preserving, rehabilitating, reuniting, or strengthening the family and such other services as will assist members of a family to attain or retain capability for the maximum self-support and personal independence."

Ever since 1962, the public assistance

programs have been generating a wider and wider scope of social services. The 1962 amendments to the Social Security Act allowed for 75 percent Federal matching for social services provided by State and local agencies. (Before 1962, such matching was limited to money payments.) Next, the 1967 amendments made the 75 percent Federal matching funds available to States for the purchase of services from sources other than State and local welfare agencies when those agencies themselves cannot provide these services and if they are not otherwise available without cost.

Purchase of services, when included in the State plan, is available under Titles I, IV-A, X, XIV, and XVI which cover, respectively, Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind and Disabled. This is spelled out in more detail in the Code of Federal Regulations, Title 45, Chapter II, Part 226 and authorizes the provision of services by purchase from other State and local public agencies, from nonprofit or proprietary agencies or organizations, or from individuals.

Title 45, Chapter II, Part 220.52 of the Code of Federal Regulations states that these services may be provided not only for current welfare recipients but also for former recipients and for those who, within five years, are likely to become recipients of financial assistance.

The State or local welfare agency that purchases these services may wield a high degree of control over the programs. It should work closely with the provider or vendor agency, furnishing consultation and technical assistance, monitoring fiscal and program elements, and making the evaluation. When an agency gives this assistance, it may deduct 5 percent of the total cost for expenses.

The agency is usually responsible for determining the eligibility of the recipients. It is also responsible for determination as to authorization, selection, quality, effectiveness, and execution of a plan or program of services suited to the needs of the people in question. In areas where licensing or accrediting standards are absent, the providing agency must meet standards or criteria established by the State agency. The purpose of this is to assure quality of service. The actual payment for services may be made either directly to the provider of the services or to the recipient of the services for payment to the service provider, depending on the kind of service delivered.

The kinds of services that can be purchased are those traditionally the responsibility of the State and local welfare agencies: *e.g.*, homemaker services, day care centers, protective services for children and adults, assistance to unwed mothers and their children, foster care, assisting the mentally ill to return to community life, and additional services required by congressional mandate.

Ordinarily, services cannot be purchased for other governmental agencies or for institutional care; but there are exceptions. If another agency has a need for social services within centers for the aging, youth, the mentally ill, alcoholics, and drug addicts but do not have the facilities for their provision, then these services may be purchased. Also, information and referral services, counseling, and casework may be purchased where necessary.

A high degree of expertise is needed to write relevant and acceptable proposals for social service programs. Most volunteer agencies must now be prepared to be involved in detailed specifications, cost-benefit analysis, productivity analysis, and the development of evaluation systems that are built into the management and administrative processes. Increased consumer participation in planning, programming, and delivery is also becoming essential.

A fast developing trend in Federal funding policy favors the "umbrella" (or multi-agency) approach to service provision. This approach is based on the assumption that no one agency can provide an adequate solution to a community's complex set of problems. Since programs are usually designed to be results-oriented, highly visible and measurable, the umbrella approach offers greater feasibility and demonstrability.

While purchase-of-service arrangements can benefit a local social service agency and the needy citizens of a particular area, there is still the question

regarding the benefit to the private organization whose services are being purchased. Not too much has been done in answering that question. Most notable was a study supported by the National Institute of Mental Health and the Laurie Fellowship of the Council of Jewish Federations and Welfare Funds. The study was made of voluntary agencies in the category of "Jewish Vocational Services." (A full discussion of this study was made by Felice Davidson Perlmutter and published in *Child Welfare*, May 5, 1971.)

Although the JVS are not truly representative of voluntary agencies, the study provides an important benchmark in the search for evidence in policy-making issues. The JVS study is also intriguing because of the long JVS experience in using public funds under the Vocational Rehabilitation Act of 1954. Sufficient time has passed for us to measure the effect of the use of public funds.

The study touched on two questions uppermost in the minds of most people involved in volunteer agencies: (1) Can a private agency retain its autonomy if it accepts government funds? will its policy be determined by the government agency that provides the money? is there a relationship between the amount of dollars received and the determination of policy? (2) Will citizen-contributors and private funding sources continue to support the agency, once it receives public funds?

The findings regarding autonomy indicated that public funding freed the agencies from dependent financial relationships on the local level and allowed them to function more autonomously in planning and determining what community services to develop. There was no relationship between the amount of government money received and the determination of the agency's policy.

As to whether or not private donations would dry up in the face of government payments, there was no appreciable change; private funding seemed to relate to the goal and mission of the agency, rather than to its use of public funds.

There is still much speculation and concern in the volunteer sector of the social services concerning these questions. Obviously there are no clear answers yet.

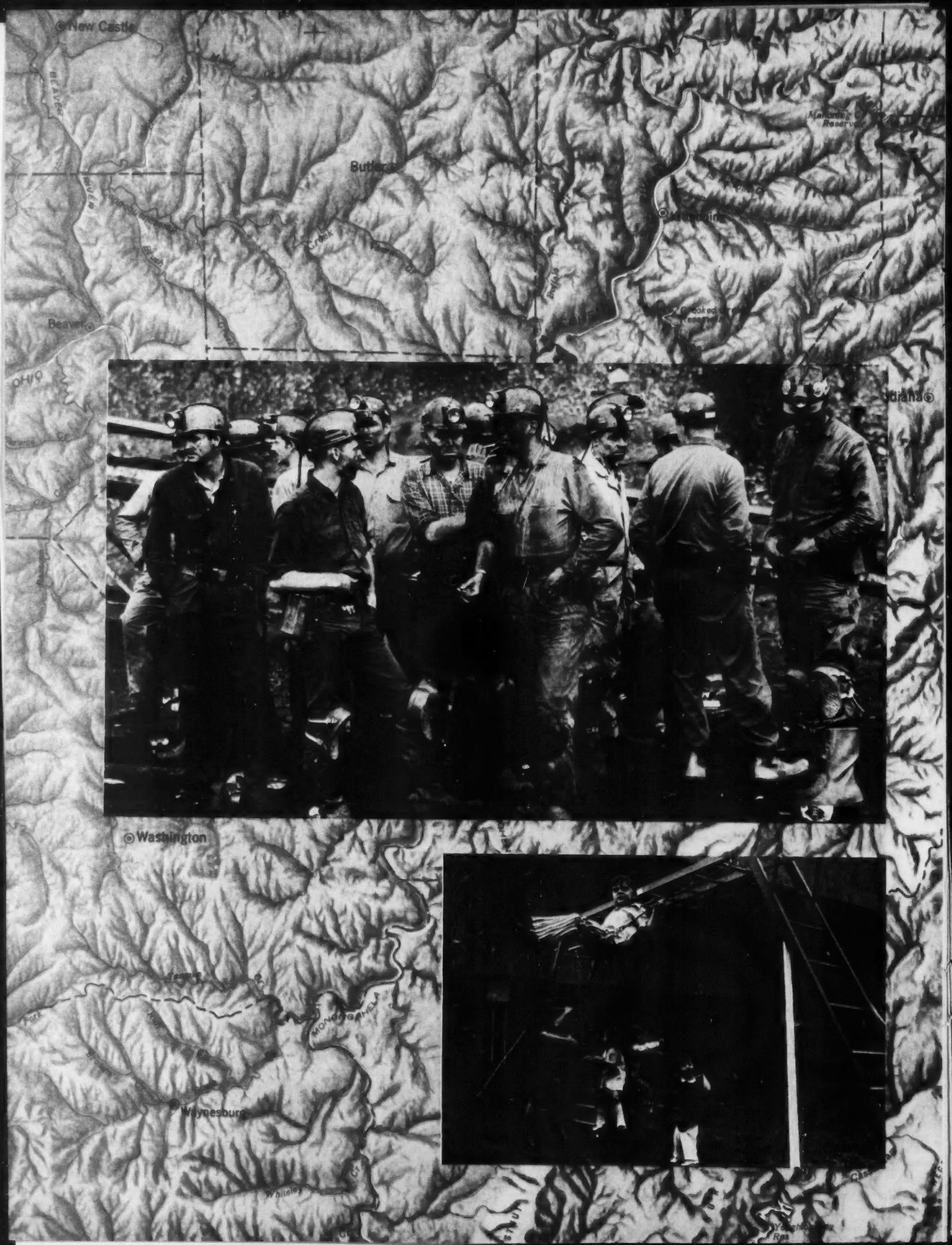
Now there is an interesting competition coming over the horizon. It is between voluntary agencies and proprietary agencies to obtain purchase-of-service public money for their programs. Last year, Booz, Allen, & Hamilton, management consultants, prepared a report for SRS on purchases of service in three States. The study showed that proprietary agencies have an advantage over voluntary agencies because of sounder administrative practices, cost controls, more back-up capital, and efficient management. Such a general conclusion has great policy overtones. At this time, however, the private voluntary agencies are more numerous and are engaged in the overwhelming majority of purchase-of-service agreements.

There are, however, two sides to the purchase-of-service story. On the one hand, it has been a mechanism enabling many local social service agencies to help needy citizens, despite these agencies' own inadequate resources. On the other hand, the open-ended spending authority has been too great a burden upon the Federal treasury.

The Federal Government was spending $1.3 billion for the provision of social services in FY72. The matching requests from the States indicated a level of $4.8 billion in FY73. Hence, the Congress has placed a ceiling of $2.5 billion on spending for social services, including purchased services. Congress also established three priority services for State and local planning: child care, family planning, and aid to the mentally retarded. After these three categories are funded, then 90 percent of what is left—that is, the difference between the costs of these three services and the total amount a State is receiving in FY73—has to be spent on programs that provide direct help to recipients or applicants of welfare. The WIN program figures prominently here.

Hence, while the sky is no longer the limit in the purchase of service, neither has this approach been flattened to the ground. In fact, it is possible that with the new funding constraints, there will be increased competition among private agencies to provide more effective, efficient, and economical service under purchase-of-service agreements; public agencies, for their part, will begin to exercise greater program controls and help escalate the quality of service through improved evaluation.

Mr. Doherty is Staff Advisor for Citizen Participation in the Office of Manpower Development and Training, SRS.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The Mon Valley Community Health Center provides assistance for more than 110,000 people in three Pennsylvania counties.

Bringing the Community into Services Integration

ROBERT PECARCHIK and J. WENDELL RAMEY. Public welfare and health delivery systems are under sharp attack in nearly every corner of this Nation. The criticism often focuses upon the unresponsive, outmoded nature of these systems and their ever-mounting costs of operation.

Various experimental projects are being conducted to determine how separate health and welfare systems might be integrated into a single human service delivery system. Such a system would assure quality and continuity of care and accessibility of services, all at moderate costs.

When the Mon Valley Community Health Center opened in Monessen, Pennsylvania, it marked the beginning of the development of a human service delivery system that would be responsive to the needs of Mon Valley's 110,000 residents. The Center's efforts may well serve as a model for thousands of rural communities throughout the country.

From a sociological standpoint, the Mon Valley might be aptly described as an ethnic "melting pot": Anglo-Saxon, Eastern and Southern European, with a scattered non-white population of about four percent.

Social and physical isolation is prevalent in the Valley; close to half the residents live in rural farm areas. In general, they have not taken full advantage of those existing health and welfare services that are typically utilized by the client/patient residing in urban areas.

Of the Valley's population, 11.5 percent is 65 years old or older, compared with a national percentage of 6.1 for the over-65 population. This high percentage is undoubtedly the result of emigration from the Valley in recent years.

The large number of elderly people plus the fact that the per capita income of residents of the Valley is only $2,500 indicates a situation of great need for health and other social services.

The Mon Valley is a "community" of 32 political subdivisions spread over 100 square miles in the heart of Pennsylvania's Appalachian mountain range. It is an area made up of portions of three counties: Washington, Westmoreland, and Fayette. They converge at a point along the Monongahela River about 27 miles southwest of Pittsburgh.

The Valley is full of inconsistencies—beautiful green valleys sheltered by barren hillsides, prosperous steel-producing plants next to partially dismantled and abandoned mills, innumerable churches of various denominations, and open farmland interspersed with suburban sprawl.

This once wealthy industrial center has suffered an economic decline. Before World War II, Mon Valley had a diverse economic base. Iron, ingot steel, fabricated steel, steel tubing, wire, nails, fencing, tin plate, glass, coal, coke, and machinery for heavy industries were all produced within the borders of the Valley. The decline came with depletion of local coal reserves, a decreased demand for glass and glass products, obsolescence in steel-producing equipment, and major shifts in steel markets.

During the time when prosperity abounded in the Valley, public "relief" was virtually unknown. But later years saw the rolls of the "poor" swelled by the unemployed or striking coal miners and steel workers.

The Valley sustained a population loss of 7.6 percent during the 1960's. People moved away in search of employment. During this same period, the Commonwealth of Pennsylvania had a population increase of 4.2 percent.

Within this complex social, economic, and political milieu the plans for a coordinated human services delivery system were conceived, nurtured, and eventually evolved.

The definitiveness of the Mon Valley trade and service area evolved out of its

isolation and the recognition by the geo-political sub-divisions of the need to interdependently seek resolutions of their common problems.

This cooperative association over the years, accompanied by the development of a limited Valley-wide public transportation and highway system, tended to weld those separate units into a single Mon Valley "community."

A move toward solidarity was the creation of the Mon Valley Community Health Center. The Center was designed to bring health services to the residents of the many small cities, boroughs, villages, townships, farm hamlets, and coal camps that had become the Mon Valley.

"Oneness" was to be seen in the title prefixes of the organizations, agencies, and groups that came into existence to serve the whole Mon Valley community: Mon Valley United Fund, Mon Valley Vocational and Technical High School, Mon Valley United Health Services, Monogahela Valley Hospital, Mon Valley Council of Governments, Mon Valley Music Association, Mon Valley Progress Council, Mon Valley Industrial Development Association, Mon Valley Health and Welfare Council, Mon Valley Community Health Center, Mon Valley Dental Society, and others.

In June 1971, at the dedication service for the community-organized Center, the services included the "umbrella" programs of the Mon Valley United Health Services, Veterans Administration, Pennsylvania Departments of Health and Public Welfare, Catholic Charities, Pennsylvania Bureau of Vocational Rehabilitation, and such non-direct service agencies as the United Fund, Comprehensive Health and Planning, and the Family Planning Council of Southwestern Pennsylvania.

Today, this services mix includes over 100 varied services—mental health clinic, public health clinics, public assistance, veterans affairs, family casework, child development centers, family planning clinic, visiting nurses, senior citizens day care center, drug and alcohol rehabilitation center, and a center for the adult retarded, for example. These services were linked together to form a system assuring a continuum of care. The non-direct service organizations were viewed as needed supplements to the envisioned research and planning tasks.

Through a coordinated system of referrals and follow-up, the Center has been able to grow as a community-organized operation. In the past there had been duplication of services and a lack of cooperation among the various health agencies. A spirit of coordination and understanding now exists, and the patient/client is given a higher degree of continuity of care and better health-related services.

Similar to many other communities throughout the country, the Mon Valley had complacently depended upon neighborhood fund drives to support categorical disease programs, seasonally-oriented social welfare agencies, character-building organizations, and other narrow-gauge charities.

The community's health needs were supposedly being met by two local hospitals and a cadre of family physicians, but the services were inadequate. Valley out-patient clinics were non-existent; patients were often referred to Pittsburgh hospitals and the medical center.

In 1961 the Mon Valley United Fund was founded. This new organization moved expeditiously to encourage the merger of many small agencies with similar fund-raising objectives and goals. Within several years, the Fund was able to conduct one annual Valley-wide campaign, allocating its resources to those few organizations which adhered to its established policies. This solidified the Fund's position as a dynamic community institution.

In 1964 the Fund commissioned a study to determine the health and welfare needs of the Mon Valley and how these might be best satisfied. The study disclosed that "many of the human services taken for granted in communities of similar size and population were lacking or, at best, were marginal in the Mon Valley." Strongly recommended was formation of a new "umbrella" agency in which a number of related services would be offered under one administrative structure. The conclusions were later reinforced by a report from the Graduate School of Public Health of the University of Pittsburgh.

In December 1964 the Mon Valley United Health Services came into existence with a small allocation from the Fund and an imaginative board.

Since its inception, the United Health

Services has grown more than 1,333 percent, providing a vast array of services heretofore not available. These include mental health/mental retardation, family planning, child development, drug and alcohol rehabilitation, community development, senior citizen, and home health services. The agency has developed a common intake procedure and maintains a common file on each client/patient or family. With a support combination of taxes and voluntary contributions, UHS has sought to assure continuity of care under its broad umbrella.

For years, the Mon Valley was forced to negotiate with three counties for support of its many programs administered by the UHS. This was a very serious problem, since the differences in each

county's priorities either negated the initiation of new and badly needed services or jeopardized the expansion or continuation of those in operation.

Prior to the construction of the Health Center, the Mon Valley United Health Services, with its multi-service program, had developed an informal cooperative arrangement with a few public and private agencies to expedite interagency referrals and follow-up. The experience proved to be relatively successful and served as the beginning of a formal coordination proposal. This eventually was submitted for contract funding to the Health Services and Mental Health Administration, Department of Health Administration, Department of Health, Education, and Welfare, as an Experimental Health Service Delivery System (EHDS). The proposal was accepted and funded in June, 1971.

The primary objective of the EHDS Project is the development of a coordinated health and social welfare delivery system responsive to community needs. The Project is designed to improve the quality and quantity of care.

The Mon Valley Community Health Center became the base of operation for all organizations and related groups working together in health-related ventures. Under the EHDS Project, health and social welfare were not two separate systems, but were the dependent and interacting components of a single system of service delivery.

Structurally, the Project is administered by a professional staff under the direction of the Mon Valley Health and Welfare Council and its 28-member board. With current funding, the Council's management responsibilities extend beyond the initial Health Center-based concept to encompass most of the health and welfare services within the Valley.

The Council is composed of hundreds of Valley agencies, organizations, neighborhood groups, professional associations, and clubs interested in the provision of health and welfare services.

Its board of directors comes from the major provider groups, payors, elected neighborhood leadership, and government. Most members of the board are either the elected presidents of provider organizations and neighborhood area councils or are the regional directors of public agencies.

This broad cross-section of Mon Valley's leadership allows for a healthy exchange of views among grass-root consumers, the president of a hospital, the regional director of the health and public welfare department, and the president of the council of governments. The day-to-day operational responsibilities of the agency are vested in the Executive Director of the Council, with assistance from the Directors of Research and Community Development.

The Experimental Health Service Delivery System Project is the most unique aspect of the Mon Valley Health Center system. There were only 12 such projects in the Nation during FY72. Mon Valley is the only one having a Health Center with a coordination component working in conjunction with a research component.

Each agency within the Center functions individually and is able to treat patients confidentially. But in order to maintain a strong relationship between the in-house coordination team and the in-house research team, all agencies are asked to feed information into the central data bank.

Clients at the Center receive identification cards and numbers as part of the intake process. A special registration form, containing pertinent information necessary for the Project study, is also completed. When the patient or client returns on subsequent visits (either to the same or another agency) follow-up information is registered. All this data is

then channeled to a central data bank within the EHSD Project. It is identified only by number. By periodic analysis, the research component is able to assess the impact of the system on the community, discover weaknesses, and recommend changes.

The analyses of such data is made available to the board of the Mon Valley Health and Welfare Council for planning and program implementation. As the need for change is determined through research, certain modifications of the program or services can be made. Rational planning can also proceed from such a comprehensive information base. This in-house management data system will be expanded at a later date to include services delivered outside the Health Center.

Analysis and interpretation have been made more efficient with computerization. In fact, this allows for almost immediate "reporting back" to the Council and participating agencies for study and definitive action. An important by-product is a simplification of interagency referral and follow-up.

The Mon Valley Community Health Center is reaping the benefits of the research-coordination operation. The two components complement each other in many ways to bridge the gap between the provider or respondent and the researcher.

In order to reach every resident, the Mon Valley Health and Welfare Council, Inc., has divided the Valley into six areas. The many groups and organizations in each area have been invited to participate in the EHSDS. A neighborhood office was established in each of the six areas to allow easy access and entry into the system. Those offices are staffed by personnel on loan from the Mon Valley United Health Services, Inc. The neighborhood-based extension workers have become excellent case-finders, particularly in the rural and isolated sections of the Valley.

Under the supervision of the Community Development Component, the neighborhood workers also staff individual organizations on request. This is in addition to area councils composed of the presidents of all neighborhood organizations within each area.

This network of local groups, area councils, and the visible neighborhood center supports the objectives of the parent Council to extend services beyond the walls of institutions and to neighborhood services at the "grass-root" level.

The Community Development Component has two primary functions: *organization/education* and *coordination.* Community organization/education focuses upon broadening community participation in the decision-making processes related to program development. This component, for example, prepares news releases for local media on eligibility for services and on the activities of the EHSDS Project.

Bi-monthly news releases are widely circulated to all leaders and interested citizens of the Mon Valley. These are supplemented by seminars, workshops, and other educational functions within the neighborhoods or at the Center. Most of these activities are requested by the community and are related to specialized health and welfare issues.

An ombudsman is available 24 hours a day to assist the client/patient in identifying those services he may need and in locating such services if they are not available within the Mon Valley. In every instance, the patient/client is tracked through the system to avoid being lost or referred out of it.

Finally, the coordination unit works closely with the research team in soliciting the full cooperation of the participating agencies in completing the "encounter forms" which are an essential part of the management data system. This is done through daily contacts with agency staffs in the Center. Monthly meetings are also held with program managers to discuss problems and make information available.

The Executive Director of the Council meets periodically with the executives of the participating agencies to report on progress. Management information is shared; suggestions and recommendations for improvement are made.

The key to the success of our venture will be the ongoing collection and analysis of utilization data from encounter and follow-up forms. Such information, when transmitted to the board of the Council, can expedite responsible program planning. This evaluation function of the system will assure community residents of a high degree of continuity of care throughout.

The cooperating agencies have generally found the system to be less demanding than anticipated. Their full support, in exchange for periodic management information to assist them in their own internal agency planning, has been considered a fair trade-off.

The physical proximity of the agencies within the Center, the sharing of information within the bounds of confidentiality, informal interagency staff contacts, release of management data analyses, the easy movement of clients between agencies, and the assistance of the ombudsman have all greatly increased the number of interagency referrals of clients.

The ultimate success of our system depends upon the full and continued involvement of an enlightened citizenry. For this reason emphasis has been placed upon community development, organization, and education, with opportunities for neighborhood entry-points into the system. Community support and meaningful participation in the decision-making process were both necessary to the accomplishment of coordinated human services in the Mon Valley. Thus, the Mon Valley Community Health Center is working toward the development of a human services delivery system destined to succeed. **HN**

Mr. Ramey is the Project Director of the Mon Valley Health Center; Mr. Pecarchik is a Research Director.

Names like "delinquent" hurt. And 40 percent of delinquent youth are branded with that name. Kids that play hooky. Kids that run away from home. Kids that need help. Otherwise, they might be called by another name: criminal. Help keep kids out of trouble—and out of court.

For more information write: Administrator, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.

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New profile of Adult Categories

HOWARD OBERHEU, SUSAN YAMAMOTO, EILEEN STENSON. Most blind, disabled, and elderly receiving public assistance are women. This is one of the findings of a just-published 1970 SRS study of the three adult categories—Old-Age Assistance, Aid to the Permanently and Totally Disabled, and Aid to the Blind.

The largest number of adult recipients are white, but there has been an increase in blacks in the categories of AB and OAA since previous studies (OAA, 1965; APTD and AB, 1962). People of Hispanic origin comprise 7 percent of the OAA and APTD categories and 5 percent of the blind and visually impaired. Native Americans and other ethnic groups are represented in very small percentages.

Contrary to the popular stereotype of people who migrate from State to State for assistance, a majority of the recipients have never lived outside the State in which they are receiving assistance. Those among the disabled who have moved, did so before 1950. In addition, most of the population surveyed had lived at their present address 2 years or more. The majority in all categories live in urban and metropolitan areas, following the general United States trend.

Length of time on assistance since the most recent opening of the case until the "study month" is also contrary to the popular idea that people are recipients all their lives. In assistance to the aged, the median number of years since the most recent opening of the case has dropped from 6 to 5.3 years. For APTD, the median time has remained a constant 2.6 years. Only in the AB category did the median slightly increase from 6.1 to 6.3 years since 1962. However, long-term cases for both AB and APTD increased.

The OAA category, of course, is influenced by fluctuations in the general life span in the United States. For a sizeable majority of all adult recipients an OAA grant is the first time for public assistance under an adult category.

Age at the time of acceptance is a factor in the length of time on assistance, as well as in the progress the recipients are able to make in coping with their life situations. Blind recipients are now younger as a group, with a median age of 59.9 years; this may be attributable to the fact that there was a marked increase in recipients who were blind at birth. Under OAA the median age has decreased to 75.5 years. The incidence of congenital malformation and injury at birth has declined to 17 percent in the APTD category; nevertheless; the median age decreased to 54.6 years and the proportion under 30 years increased.

Although about half the recipients have living children; however, very few have children contributing to their support. Among the elderly in particular there has been a considerable decrease in recipients who have children contributing regularly to their parents' support.

Most spouses living with OAA recipients continue to receive some type of assistance. Of these, 67 percent receive assistance in their own right, while 15 percent do so as a member of the recipient's assistance group. Other types of assistance received by spouses of the elderly, in order of frequency, are APTD, AFDC, and AB.

About 1 in 4 blind persons has children living in the home. Of all AB recipients, 11 percent have children financially dependent on them for support.

A more complete picture emerges with the finding that many recipients live alone. About 2 in 10 of the blind live alone; 3 in 10 have never married. AB recipients living with spouses declined slightly, but the level of those who are married remains at 30 percent.

There was a slight increase in divorce and separation among the disabled; 37 percent, however, never married.

The marital status of OAA recipients remains much as it was in 1965. Half have been widowed, while 25 percent are married and living with a spouse. A smaller percentage of OAA recipients are alone because of factors such as their age and continuing physical and mental handicaps that have prevented wide social contacts. Part of this isolation might possibly be attributed to urban living, which promotes the one-person unit and works against the extended family.

However, there is a balance between the possible good and bad effects of the recipients' shift from rural to metropolitan living. In APTD there has been a decline in institutionalization: more disabled people are now encouraged to be as independent as possible. In the past, a person with a handicap might have been tightly bound by societal restrictions. With enough encouragement, such an individual can now begin to forge his own life style, regardless of how limited it may be in comparison with the able-bodied.

Urbanization may have had one positive effect on the education of the blind and disabled. On the average, APTD recipients had a higher level of education in 1970 than in 1962. This rise matches the overall rise in the educational level that has occurred among Americans dur-

ing the same period. Blind recipients in particular gained in this area: numbers of blind high school graduates and those with some college nearly doubled to reach 10 and 4 percent, respectively. In 1970, 1 in 7 blind recipients had completed a vocational training program, usually in trades and crafts. The use of specific blindness-related training and training aids increased.

Education and urbanization do not go hand-in-hand where the aged are concerned, however. Their educational level remained low. In 1970 only 2 percent were known to have completed a vocational training program.

In contrast to the constant complaint that public assistance recipients have been loafers all their lives, 69 percent of the aged have a history of previous employment. Almost 1 in 4 OAA recipients had been employed as a service worker. Each of the other major occupational groups (blue-collar, farm, and white-collar workers) was less frequently represented. AB recipients employed full time increased.

Of AB recipients with labor market experience, the most frequently reported occupations were blue-collar. There was a decrease in disabled recipients who had never been employed; in fact those currently employed or employed within the past year increased to 6 percent.

In general recipients in each category are more mobile than ever before. The findings in the AB category are particularly striking, because 1 in 4 of these persons can now negotiate the world outside his home unaided by person, dog, or device.

Among OAA recipients, 2 in 3 continue to live in their own homes. There was a shift from privately-owned to rented housing: renters now comprise 45 percent of OAA recipients. APTD recipients who live in their own home remained at 54 percent; those in institutions comprise 13 percent; while 2 percent are in group quarters.

Physical illness seems to continue to be a major factor in the need for public assistance. Mental illness is a factor to a lesser extent, but there are usually emotional adjustments to be made when a physical problem is present. APTD is, by definition, a category outlined by physical problems. Diseases of the circulatory system continued to be the most frequently reported primary disabling condition, although decreasing from nearly 3 in 10 to 2 in 10 among recipients. Over a third of the disabled were either mentally ill or retarded.

Nearly half of the APTD recipients received one or more social services. Three in 10 received social services related to physical functioning, including physicians' and outpatient or clinic services, while nearly 1 in 10 received social services related to mental functioning, including physician's and outpatient or clinic services and assistance in admission to an institution.

The supportive or sustaining services received by 1 in 10 recipients included homemaker services, chore services, social outlet services, and volunteer visiting services. Two in 10 recipients received other social services, including referral for vocational rehabilitation services, counseling and information about family planning, and directions for gaining assistance with mobility or self care activities.

In 1970, 63 percent of OAA recipients had one or more chronic health conditions. After "the big three"—circulatory diseases, arthritis, and rheumatism—the most frequently reported illnesses are diabetes, mental illness, digestive diseases, and respiratory diseases. Small percentages for cancer, alcoholism, and tuberculosis were reported.

About 3 in 10 OAA recipients received one or more social services. The most common type of social service related to physical functioning was help in obtaining a physician's services. Among the few who received social services related to mental functioning, the most common type was assistance in gaining admission to a skilled nursing home.

Although there were more AB recipients blind from birth, there was a decrease in the totally blind from 18 to 16 percent. Deafness continued as the major secondary impairment among AB recipients. In addition to their physical and mental impairments, other chronic health conditions affect 4 in 10 blind persons receiving assistance.

In the receipt of social services by AB recipients, there was an equal balance of 25 percent between social services related to physical functioning and social services related to housing improvement, referrals to (or joint planning with) vocational rehabilitation, or arrangements for getting a talking book machine. Of the 16 percent of AB recipients receiving supportive or sustaining social services, 6 percent received homemaker services and only 4 percent were referred to social outlets, such as senior centers.

The general population ought to obtain a better understanding of the severe problems that illness, injury, and defects can create in the lives of Americans, especially the poor. Then the public may be in a better position to support advances in health, education, and rehabilitation. If weather modification, organ transplants, moon travel, and computers are now part of everyday life, then we can make the new rehabilitation techniques into realities, also. Our society manufactures so many disposable goods that there is a tendency to throw away people, too. However, as the 1970 data indicate, even our most vulnerable citizens are waging a powerful struggle to survive—not to be discarded by the young, able-bodied majority. ■

Mr. Oberheu, Ms. Yamamoto, and Ms. Stenson are analysts of the staff of the National Center for Social Statistics, SRS. Their data is based upon *Findings of the 1970 OAA/APTD/AB Study, Part I. Demographic and Program Statistics*, published September 1972; single copies available from SRS.

How to make Job Banks work for the Handicapped

FRANK ATELSEK AND EVA MACKIN.

Finding a job can be a tedious, numbling, uncertain task. This is especially true for the handicapped individual who must find a job and a work environment that offset the limitations of whatever is his handicap. But persons with handicaps usually end up in jobs that do not fully use their actual skill or exploit their potential talent.

A great deal can be done, however, to help handicapped persons take full advantage of recent innovations in job-search techniques. Of special interest are those services made possible by computerized Job Banks: the refinements in job analysis and matching worker profiles.

The Job Bank itself is relatively new; the first was established in Baltimore, Maryland, in 1967. However, more than 100 others have been developed since then. By now all major cities and many smaller areas in every State have computerized Job Banks operating in State Employment Service offices.

Basically the Job Bank is a computerized daily listing of all job openings given by employers to the State Employment Service. Although the completeness of the job listing varies from area to area, the Job Banks typically include a broad representation of vacant jobs.

In its present form the Job Bank listings are something like the "help-wanted" ads in the daily newspaper. But there is an important difference: substantially more information about each job opening is presented and a job counselor can acquire additional necessary information before referring an applicant to his prospective employer. Typically, the Job Bank listings are also changed daily as jobs are filled and new openings are announced.

The openings listed in the Job Bank are divided by type of work (*e.g.*, all the clerk-typist jobs are in one place). In some larger metropolitan areas the jobs are arranged according to their geographic location as well.

The company name and location and the name of the person to whom an applicant is to report are available only to the Employment Service Placement Officer in order to ensure referring only that number of job-seekers the employer wishes to interview.

In some Job Bank operations, the job openings can be catalogued according to the educational level needed to perform the job tasks; the amount of supervisory and training time needed; the worker's aptitude, interest, and temperament characteristics appropriate for the job; the physical demands of the job; the working conditions; and related fields.

Even where such complete job information is not collected, standard references on occupational analysis (prepared by the U.S. Department of Labor) can be the basis for lists of jobs that could be performed by handicapped individuals. To increase their usefulness to VR counselors, different lists could be prepared for each of the major handicapping conditions.

Such lists would alert counselors to occupations they might not have previously considered. They would also make it easier to use the Job Bank, since the proposed lists would focus attention only upon those occupational codes and job openings most relevant to a particular client. However, if such listings are prepared, the users must understand that the list is primarily a time-saving aid. They should not be regarded as definitive nor should they in any way be used as a device for limiting the jobs available to handicapped individuals.

During the past four years we have completed several studies of the job-search problems of handicapped and other hard-to-place job-seekers. The studies were conducted from a variety of perspectives, including employer reservations about hiring the handicapped and the information problem of the vocational rehabilitation counselor in his role as job placement specialist.

These studies, along with related surveys and numerous discussions with rehabilitation counselors on jobs for the deaf brought to light several difficulties which limit the effectiveness of counselors in placing the handicapped person.

First, we found that rehabilitation counselors often have only a few employer contacts and lack any access to the full range of job openings available in an area.

Second, it appears that few counselors have the time or the background to create a job development and placement strategy for their handicapped clients.

Third, although there are wide variations with ways VR counselors find job openings and place clients, these efforts in the main are highly personalized. When the counselor must locate work for a job-ready client, he typically begins a canvass of familiar employer contacts, particularly those who previously hired VR clients with disabilities similar to those of his current job-seeker.

Fourth, the critical determinant in the job search seems to be the employer's favorable disposition toward that particular type of client. Finding the job that maximizes the client's potential and directs him to a more meaningful work career is often viewed by counselors as an unachievable ideal. The underlying premise is that jobs for handicapped

persons are not easy to find and that you have to compromise on a job placement that is not really right but is nevertheless "safe" and available.

Fifth, we were distressed to note that few counselors keep employer information files in a systematic way. Hence, when an experienced counselor is promoted or leaves, his information leaves with him. New counselors always seem to start from scratch to develop a pool of employer contacts. The implications of this become quite serious in light of other data, such as a 1970 study by Norman L. Tully of rehabilitation counselors who work primarily with the deaf. That study indicated that job turnover among the counselors was quite high; 65 percent had been in their jobs less than two years.

Sixth, on-line counselors in many rehabilitation agencies are not provided with the support and services they need to guide their clients into jobs commensurate with their work potential. Relatively few agencies employ a specialist on the local labor market to provide counselors with the necessary leads to develop jobs for handicapped clients.

Seventh and finally, short-term follow-up after job placement is well recognized as essential to the rehabilitation process.

Long-term follow-up after official closure is rare, though the need for it is strongly advocated by working level rehabilitation counselors and other professionals. Few counselors are able to fulfill this perceived responsibility to their own satisfaction. Some counselors find a means of fitting this service into their work-loads; others, because of the pressure for closures and the burden of their caseloads, cannot.

In the context of the above "state of the art" in job counseling for the handicapped, the Job Bank concept is essentially sound and could prove extremely useful. To make it so, however, would require some preliminary steps now, while the Job Banks and their formats are still evolving.

The primary advantage of adapting Job Bank principles to the needs of the handicapped is to diversify job opportunities far beyond the range of jobs that counselors can generate individually. For example, computerized man-job matching — using a computer to match the experience and characteristics of an applicant to the requirements of a job— is still being tested. This technique can be useful, but its limitations should be observed.

One of the major deficiencies in the continued development of computerized job-search services is that the needs of all potential users are not adequately being taken into account. This is particularly true of subscriber agencies such as departments of vocational rehabilitation.

Officials in regional and State rehabilitation services ought to take the initiative and make sure their agency needs are known so that the Job Bank system can be more useful to them. Line rehabilitation counselors are well aware of the Job Banks' present inadequacies and may have a reasonably good idea of ways to make the system more pertinent to their needs.

However, few counselors have the time, position, or the data base on occupations, industries, and computer technology to be effective change-agents themselves. Fortunately, many States are moving toward comprehensive approaches to human resource development; such approaches require the concerted efforts of a wide variety of public and private agencies. Now is an appropriate time for any vocational rehabilitation service to analyze the Job Bank operation in terms of its own needs and to suggest alterations.

Some suggestions that might warrant further investigation are the following:

- A computerized scanning system to flag jobs according to physical demands and/or educational requirements.
- Making available training programs in job analysis, employer relations, occupational and industry classification, etc. to rehabilitation counselors as part of their in-service training; such training would increase their skills in job development techniques.
- Clarification on the extent of contact which participating agencies can and should make with employers on their own. (In the early days of the Job Bank,

participating agencies had to agree to work exclusively through the Job Bank. Though this rule is broken frequently in some areas, the question of employer contacts must be resolved to avoid problems for the employers, the job-seekers, and the participating agencies.)

The involvement of rehabilitation professionals would also likely lead to alterations in the format of Job Bank listings, making them easier to use by everyone, including rehabilitation clients.

It should be noted that the handicapped individual heading into the job marketplace is more sophisticated and has had better training for the job-seeking task than has been the case in the past. While job counseling for the handicapped is still a developing profession and while the application of new technology (such as the Job Banks) is still on the horizon, there is yet much to be praised in the present situation.

A number of excellent programs are in place around the country, affiliated with social service agencies—public and private—as well as with schools and particular industries. For example, the academic and vocational program for deaf persons in Seattle Community College utilizes faculties and training facilities within the community college district.

Aided by a joint grant from the Social and Rehabilitation Service and the Office of Education, both agencies within the Department of Health, Education, and Welfare, the College's program for the deaf involves its students in a job-sampling schedule in which the students observe and even try out—to the extent possible—different jobs in the College's own classes and shops, which are quite varied. The conclusion of this sampling schedule is a week spent in each of two or three vocational areas having the most appeal to the student.

Students in the deaf program also receive a steady flow of information about the world of work. The data include starting salaries, normal pay increments that one could expect, fringe benefits, the requirements for apprenticeship, the degree of unionization, the advancement potential, and the level of demand for the particular skill under discussion. In addition, the student is put through the exercise of properly filling out application forms, checking off insurance preferences, dealing with personnel staffs, and in other ways getting used to the introduction to a work environment.

The Seattle program lasts two years, the usual community college commitment, and has been called "one of the most extensive occupational programs on the West Coast." As the photos accompanying this article indicate (they were taken at the College and in the Seattle job area), the range of vocations pursued by the deaf is quite broad. Among the 75 or more vocational-technical areas in which deaf students prepare for employment are advertising, welding, apparel design, banking, photography, heavy duty mechanics (diesel, etc.), dental technology, automobile repair, and electronic data processing.

This is just one example of many that appear around the Nation. The point here is that the handicapped person is more than likely already acquainted with the world of work, has had some training in one or several vocational areas, can cope with personnel offices and the placement process, and will otherwise fit into the job-seeker category with a minimum of unease—dependent, of course, upon the extent of his or her handicap. That is the main reason for our conclusion that now is an appropriate time to make the technology of job search and placement flexible enough to incorporate information that serves the handicapped job-seeker.

Many difficulties can be anticipated. Differences in agency regulations, procedures, and reporting requirements, as well as varying philosophies about employment problems and client services, seem bound to arise and will no doubt impede interagency cooperation for improving Job Banks. But, difficult as the process may be, it would seem to be an essential step, if the rehabilitation services are not to be left in the backstream of manpower services. **IN**

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Nassau County has found a way of distributing assistance payments which prevents loss or theft before delivery to clients.

The Way to Establish "No-Check" Welfare

CAROLYN M. PEIPER. For many years welfare agencies have been concerned with the problem of lost or stolen checks. No matter how vigilant postal personnel or neighbors have been, some recipients continued to suffer from a sudden cut-off of funds.

One alternate method to the mail is a direct delivery system whereby recipients pick up their payments at designated banks. Such a system could assure the reliable delivery of payments to recipients by circumventing the possibility of lost or stolen checks.

Philadelphia, Pa., and the Nassau County, N.Y., Department of Social Services have initiated such delivery systems on a pilot basis. (New York City, Harrisburg, and Pittsburgh are considering similar projects.) The Philadelphia and Nassau County plans are generally similar, with one significant difference: Philadelphia distributes checks through banks, where recipients may cash them upon receipt; Nassau County distributes cash.

The Bank Distribution Method in Nassau County is known as the "Nassau No-Check Plan." It was introduced on an experimental basis in February, 1972. The plan provides for non-employable recipients of Home Relief and AFDC, who live in the Lynbrook-Rockville Center communities of the County, to pick up their twice-monthly assistance payments in cash, at their choice of one of eight designated bank branches.

The program was initiated to provide an improved payment delivery system to recipients; to eliminate lost, stolen, and fraudulently endorsed checks and the related costs; and to reduce the cost of mailing checks.

The limited four-square-mile area of Lynbrook-Rockville Center was selected principally because it offered a cross-section picture of county welfare populations and had a sufficient number of banking facilities.

Approximately 400 recipients are included in the program. This represents about 40 percent of the total caseload in the geographic area covered. The eight bank branches vary in the number of recipients served in this program, although no bank has more than 100 participants.

Discussions about the need for a new and improved money delivery system to welfare recipients in Nassau County led to the formation and first meeting of an executive planning committee in March, 1971. This planning group, which became known as the "Nassau No-Check Plan" Committee, was intra-governmental; it included the County Treasurer (Chairman), County Attorney, and the Commissioner and other executive personnel of the County Department of Social Services.

Immediately involved with this committee as continuing participants throughout the planning stages were officials of the Long Island Bankers Association (LIBA), the County Bureau of Management Information, and representatives from the Department's Advisory Board of social service clients.

The Committee made several fundamental decisions to plan a new payment delivery system based upon careful and strategic considerations of various factors. Among these were decisions on the delivery system itself (a checkless distribution system through banks); on whether the system would be initiated countywide or on a more circumscribed pilot basis; the geographic location of the pilot site; and the basis upon which recipients would be selected to participate. The banks required a photo identification (ID) card for payment; hence, the State Department of Social Service required an initial issuance of ID cards for

SSPA 550 - 10/71

CASE NO.

DATE

NOT VALID AFTER

THE COUNTY OF NASSAU

MINEOLA N. Y. 11501

SOCIAL SERVICES PAYMENT AUTHORIZATION

1005507

SERIAL NO.

BANK CODE

CATG
UNIT
AUTH
NR–FNP

PAY EXACTLY

DOLLARS

NON-NEGOTIABLE

VOID

⑈1005507⑈ ⑆0214⑆1126⑆ 065⑆00115 8⑈

PAYMENT RECEIVED

RECIPIENT SIGNATURE

IF ENDORSEMENT IS MADE BY MARK (X) IT MUST BE WITNESSED BY A BANK OFFICIAL OTHER THAN A TELLER.

WITNESS SIGNATURE

VOID

IN NO CASE IS THIS BANK AUTHORIZED TO PAY OUT ANY AMOUNT OTHER THAN SHOWN ON THE FACE OF THIS FORM

persons involved in the pilot project.

In early December 1971 a letter was written (in English and Spanish) to announce and explain the new "No-Check" payment delivery system. The letter went to all Home Relief and AFDC clients in the pilot area who would no longer be getting their checks at the State Employment Service Office.

Some clients responded that illness or other conditions would prevent them from coming to the bank regularly for payment. A county welfare worker made home visits to discuss their particular problems and to determine the payment delivery method on an individual basis.

The notification letter also set a time for a photo to be taken and the necessary ID card to be issued. A listing of the participating banks was included, also. The recipient was to designate the one bank from which he or she wished to receive the assistance payment. Follow-up notices were mailed later in December and again in early January to clients who did not keep their photo appointments.

The identification card issued by the County agency, according to standards set by the State Welfare Department, is a permanent, plastic card with a color photo of the bearer. It is embossed with the New York State seal, carries the signature of the County Commissioner, and lists the recipient's name, signature, and case and Social Security numbers. At the time the ID card was issued, the client designated the bank of his choice on a separate form. A copy was given to the client for his reference; the original was filed by the welfare worker.

For the first month of operation, a welfare worker was assigned to each participating bank on the first day of each payment period. The worker answered questions and provided general help and direction to recipients.

In addition, the recipients in the program had been given a special telephone number to call for answers to questions or to explain an inability to come to the bank. This telephone was located in a centralized unit in the welfare department, staffed by a small group of workers and a supervisor who had received special training in the particulars of the new system.

The operation of the "Nassau No-Check Plan" is basically rather simple. Instead of the issuance of individual checks, the County Treasurer prepares a non-negotiable voucher in the exact amount of money each client is to receive. (The front and back are illustrated here.) In addition to the date and amount of payment, the voucher shows the client's name, address, and case number.

Recipients receive vouchers for amount of their payments.

After a computer run produces them (separately for each bank), the vouchers and a listing of recipients in case-number sequence and a check for the total money amount is transmitted from the County Treasurer to the Department of Social Services four days before the effective date for payment to the client. The Department pre-audits the vouchers and listings. Next, the Department delivers them by messenger service to the respective individual banks two days in advance of the effective payment dates.

On the day of payment, the recipient presents his photo-ID card to the bank teller and signs his name on the endorsement line on the reverse side of the voucher. (If the client cannot write, his mark is witnessed by a bank official other than the teller). The teller compares the information on the ID card with that on the voucher, makes the full amount of payment to the client in cash, and machine-validates the voucher to show that payment has been made. There is no service charge or cost to the client.

The recipient picks up his payment at the bank twice a month. The first payment is available to him on the 1st of the month and remains payable for 14 days; the second payment is available on the 15th of the month and remains payable through the 30th.

The first months of operation have shown that almost all recipients pick up their money during the first three days of the eligible payment period.

If there are any questions—either about the amount on the voucher or if there is no voucher at all—clients and bank tellers are advised not to engage in disputes or arguments. Rather, the client is to accept the payment offered and then contact the welfare office directly for an adjustment or a new check; if warranted. The special telephone number for this purpose appears on signs (again, in both English and Spanish) displayed in the bank.

Within 25 days from the close of each payment period, the bank provides the Department of Social Services with an accounting or reconciliation of the vouchers and the recipient listings. This reconciliation is accompanied by the bank's check, payable to the County Treasurer for the amount of any unpaid vouchers. So far most banks have returned the vouchers and the refund check within a week or ten days of the closed payment period.

Notice of any failures by clients to pick up their grants at the bank is sent to the Department of Social Services. A routine agency follow-up takes place. A minimal number of recipients have failed to collect their money from the banks. During the first month of operation, eight vouchers were returned unpaid. That's the highest number so far.

Customary bank services are available to the recipient: checking and savings accounts, money order purchases, utility bill payments, and the sale of Food Stamps. Some banks have conducted informal educational campaigns to encourage clients to take advantage of bank services. Banks vary, however, in

the number and kinds of services available to their customers; *e.g.*, all banks do not sell Food Stamps.

Since less than 100 recipients in this project are served in any one bank and the average transaction takes about a minute and a half, the banks have no real problems of increased volume or workload. The program has worked smoothly thus far, becoming absorbed into the regular ongoing functions of the bank.

The client continues to receive his payment from the bank branch he first selected, unless he moves out of the pilot area. Conversely, an address change *into* the pilot geographic area brings the client into the "No-Check" system. The new client who moves in may receive his first payment at his new address by check because of the time needed to select a bank, get an ID card, and fully enter the system. Such adjustments can be made within 24 hours of notification.

After the vouchers are delivered to the bank branch (48 hours prior to the effective date), a client's payment may be withheld only by direct contact from an authorized member of the Department of Social Services to a designated executive officer of the parent bank. The bank executive telephones the branch bank and the recipient's name is crossed off the listing and his voucher is cancelled. The need for such action has occurred only once in the first four months of the test operation. However, the Department of Social Services does plan to continue to develop a better, more systematic approach to handling last-minute removals. When the program expands into larger areas, it can be assumed that the potential volume of removals would be increased.

The evaluation committee, established at the initial phase, is currently developing cost figures to determine whether this new payment delivery system is less expensive to operate than the conventional one. Therefore, it would be premature to discuss definitively the costs of operating the pilot project. However, in regard to some administrative costs, the following observations can be made:

- There seems to be no special administrative savings realized from eliminating the preparation of individual negotiable checks because, in their place, individual non-negotiable vouchers of the same size and weight as the checks are prepared.
- The system does eliminate the costs involved in issuing duplicate checks to replace checks which have been lost or stolen. The prior extent of this problem in the area covered by the project is not known; however, implications for such savings are apparent for those areas in which large-scale problems of this kind occur.
- The cost of mailing the conventional checks—16 cents per recipient per month—is virtually eliminated under the new system. In addition, the agency messenger service which now delivers the vouchers to the banks is to be replaced by the bank's own messenger service, as the program expands.
- Under the pilot project the Department has not been charged an administrative fee for handling the voucher forms. However, such a charge for services is now being considered.

Community reaction to the new system in the pilot area has been generally very favorable. The local Economic Opportunity Commission of Nassau County has given firm support to the project and cooperates fully in making it work well. The same is true for the client representatives on the planning and evaluation committees.

The banks have shown support and approval of the system, primarily because it is safer than the traditional system and removes the possibility of fraud.

The new system received good publicity from the start, which was helpful. It was publicized in *The American Banker* and there have been stories in the *New York Times* and other newspapers. As a result, frequent inquires have been made to the Department from other State and local agencies.

One area of conflict between the banks and the Department of Social Services is the issue regarding indemnification for losses. The Bankers Association twice proposed an indemnification agreement since the program began. However, the Department and the County Treasurer have adamantly resisted on the basis that the project was set up to prevent fraud and speed up delivery, with the onus of accuracy to remain with the bank teller. Bankers' representatives feel this issue may become a barrier to expanding the system.

The Department recognizes, however, that the pilot area and its 400 recipients did not turn up all of the problems a full-scale operation would face. Thus, plans are being made to add a second pilot area before the end of the year, a larger area with a higher client population.

If the second, larger pilot project is deemed successful the Department would propose that the system be gradually phased into countywide operation.

The Department's longer-range plans include improvement on the present system so that the client's grant will be tied directly to a computer and instant payments could be authorized. With on-line computer service, the Department will no longer have to issue vouchers or other forms to banks; instead, a teller will receive the necessary information by dialing the computer for the amount still authorized under the grant. This will allow the welfare client to withdraw against his grant according to his needs, while the remainder of his grant is banked in the computer.

While the "Nassau No-Check" plan is still quite new—and similar plans in other States are under serious discussion—there is enough evidence to indicate that such an alternative delivery system is timely and possible. ■

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RODRIGUEZ

BINGO

What's left for Nuestros Viejitos?

ABELARDO DELGARDO. Nuestros ancianos or nuestros viejitos means our oldsters in Spanish. And for some time now I have been observing the way we Chicanos deal with our ancianos, our abuelitos.

Through our inherited Indian and Christian ways an obligation was upon us to care for the oldest members of our family until they passed away. The abuelito or casique was much respected and very much a full member of our community. If there was a Pachanga or other social function, he or she would be worthy of our respect and special attention.

This is gradually but very systematically changing. The viejitos are now put into old folks homes or housing designed for senior citizens or in nursing homes. You can see this by merely checking these institutions for Chicano last names. But my real concern is whether *those* institutions are ready for *us*, now that we are ready for them.

I looked into some of these facilities in my own community, El Paso. Here we constitute a large segment of the population, the majority, 56 percent. Talking with staff, managers, but mainly with the patients or boarders, I began to collect some observations.

Being a Chicano, 40 years old, with a mamacita who's 55 (though still very strong), my interests have been somewhat personal. But I must also try to articulate what the hundreds of wrinkled faces told me, what the tired eyes with distant looks, the shaky hands, and their heads—cana-white—think of what is happening to them.

In these homes there is very definitely a neglect for cultural and language considerations. Many a time, a manager or director that I spoke with was too overburdened with paper-work and trying to please Washington or the State welfare office or keeping records straight for Medicare to really be concerned with differences or peculiarities among his clientele. So it is my burden to point out some of the cultural differences that our viejitos have.

First of all, our language is the window of our culture. I found many of our viejitos in these institutions to possess only their native Spanish language. This presents a problem to non-Spanish-speaking staff, who have to rely on other staff or other patients for translations. I found a manager who had roomed an Anglo who did not speak Spanish with a Chicano who didn't speak English. It so happened that both the Anglo and the Chicano wanted little or no conversation and so the arrangement worked this time. But at other times this adds to the loneliness of people who have to spend every 24 hours together.

In my visits I met a man—we'll call him Alfredo—who saw me pass his room and begged me to stay. He talked and talked with me until a smile came to him; he felt fulfilled in merely having found a Chicano ear to listen among so many "gueros." Don Alfredo's main ailment was not just old age. He was neglected by his own sons and daughters, who were too busy to visit him.

I walked into another home for aged women around noon and it was filled with "muchachas"—they referred to themselves as "the girls." It was lunch time and I was invited to stay and eat. I was surprised with the menu: corn tortillas made by hand! The two cooks were Chicanos; they have a Chicano menu every day. It conflicts with the requirement that a "balanced meal" be served. We Chicanos tend to overload on starches and, of course, chili is not too good a food for the aged. And yet I saw Dona Inez pull out a jalapeno pepper from her bag and sneak a few bites.

Food is very important. I found it on the top of the list of many of their complaints. You can actually force an old woman or man into starvation, if you insist on Anglo food. A few good dietitians have learned the food value of Chicano foods and can intermingle them in their "balanced" menus.

White man's medicine is yet to be fully accepted by the Chicano community, especially by the older generations

whose roots are rural and, in most cases, in Mexico itself. They do not trust pills and drops. They have a dreadful fear of hospitals, where most of their friends went only as a last resort—to die. Juanita, 87 years old, whose son is in California, died because—even with an acute case of pneumonia—she refused to go to the hospital.

Nuestros ancianos rely on their folkways to cure most of their common ills. Mostly they rely on yerbas. Some of these herbs do have some medicinal value and are probably, in raw form, the same pills that industry markets as modern drugs. If the staff was also knowledgable of what for that age has both medicinal and psychological value, they would promote them rather than prohibit them.

Dona Rosa in another nursing home I visited was one of many of our Catholic viejitas who have lacked an education or some enlightened clergy and have had to rely on their own superstitions to fill religious needs. Consequently I found Dona Rosa to be a devout person who prays regularly to San Martin Caballero. Below the small framed picture of San Martin there's a glass with water and sometimes a little hay. This is for San Martin's horse. Naturally, the water evaporates and the hay blows away, but it is thought that the horse visits and truly eats and drinks. I don't argue with Dona Rosa. I sit down and understand Dona Rosa.

Along with the habit of putting water for San Martin's horse are the "vigil lights." While I know they could start a fire, I also understand that you may also stop the fire of the life of a viejito or viejita by depriving them of their velandoras and their santos.

La novena, praying together for nine consecutive days to a patron saint, is a form of socio-religious activity among many of those I visited. Some did their novenas alone, but many preferred to invite their friends.

Culturally we speak through our songs and music. A common fight is to change the music from Anglo to Spanish, when one speaker system or radio serves all. The same goes for TV programs. Here in El Paso we are fortunate to receive channels from Juarez, Mexico. Any promise of continuity is welcome, so los viejitos are ardent fans of TV soap operas which unfold on a continuous day-to-day basis and provide a degree of expectancy. But when I mention soap operas, I am not referring to "As the World Turns" but to a good "novela de la revolucion."

I was impressed to find that many administrators, particularly when they are Chicanos, are highly sensitive to these special values and preferences. Take a common recreational outlet such as Bingo. Our "bingo" is not a bunch of numbers but a loteria with pictures which we have traditionally recognized.

"Our 'bingo' is not a bunch of numbers but a loteria . . ."

Even there, the differences are obvious.

Our abuelitos fulfilled a teaching function when formal education was lacking. By word of mouth, through the cuentos that they would tell with great delight, we learned our culture, our ways, our values. With this aging figure disappearing from the Chicano home, I fear a huge historical and cultural vacuum is developing in our Chicano community. Yet, not only do the sons and daughters rebel against that traditional obligation to care for their old; the old, too, love their independence. A home of their own—even an institutional one—guarantees to them this independence.

Our city is lacking in alternatives to homes and institutions. The same story of long waiting lists was told by the managers of the two large high-rise housing units the city now has. I was happy to learn that two more high-rise units are planned for South El Paso, a barrio which is almost 100 percent Chicano.

The barrio is near Juarez, Mexico, and is also near downtown El Paso. For our abuelitos who lack transportation, the place is ideal. It has one of the area's oldest churches, Sagrado Corazon. The old people of the barrio congregate in tenement houses where rent is cheap and they can have their plantas and their canarios.

There is also a successful casa de los ancianos for women, 19 Chicanos and one Anglo. From a tenement-style place, where there was cooking, washing, and eating done in each unit, it evolved to what now is a well-planned community. The manager spoke to me about each individual with a sense of pride and joy in her work. She told me of handling the money for some viejitas who could no longer do it themselves. She described Senora Luz, who used to feed pigeons and who exclaimed, at the first attempt to stop her from doing that, "These palomas, like me, belong here in the barrio." Senora Luz pays a youngster to feed them, since she can no longer do it inside the home.

The manager pointed out Dona Lola watering her plants and said, "See those plants? If I were to take them from her, not only would the plants die, but so would she."

There are only two alternatives for the aged Chicano: a nursing home or a housing authority unit. In El Paso, like most other cities, I would guess, the choices are rather limited. One nursing home somewhat far from the city was recently closed down for failure to meet standards. It was run by an Anglo couple who spoke of their dedication to their work, but did not have the money to upgrade the facility. Four other nursing homes are in operation for the viejitos needing medical attention; but even among all of them, only some one thousand beds are available.

It is obvious that the necessity for such institutions will pry the necessary

funds loose to build more nursing homes, as well as housing units for those still able to function independently. What concerns me is that these institutions must not lose human values, which should be written into the very blueprints. Take the simple task of putting up a set of tendederos. These are clotheslines. Most of our viejitas prefer the good El Paso sun to dry their clothes, rather than the gas dryer.

Here are some suggestions based on my observations during the time I infiltrated el mundo de neustros viejitos.

Staff should hold sensitivity training sessions so that cultural differences of Blacks, Chicanos, or Indians can be ackowledged. By now, in each community, there are enough articulate and knowledgeable people who could conduct them.

Most places I visited were extremely clean; yet, this spotless environment is also artificial. I would have welcomed a bit of home grime, if it could lift the spirit, or anything to eliminate the antiseptic mood of these nursing homes. It was depressing for me to be in some of these places only a couple of hours. How much more so for the "jefitos" and abuelitos who stay there two or three years.

But I reserve the strongest language for our Chicano community. We must continue to care for—and care about—our papas y abuelitos, whether it is in our own home or in a nursing home, by visiting them and let their nicetos, their grandchildren, be with them. Some youngsters today actually fear viejitos because they have not been exposed to them.

We must not just dump and forget them as discards. We can give our viejitos a meaningful and well-earned rest. But we must be concerned *with* them, rather than merely for them. IN

Mr. Delgardo, a prominent American poet, is currently on the faculty of the University of Texas at El Paso directing a program of Chicano studies.

And What Shall I Do Now?

and what shall I do now . . . ?
ask the wrinkles on the woman's face
chasing with her distant look her mind
and what shall I do now . . . ?
asks the cleanly shaved, gum-chewing man
from his wheel chair and sandaled feet.
now that the four walls of this
nursing home as well as the
roommate are foreign,
the manager, the nurse, the cleaning woman
all strangers . . . they don't even speak Spanish.
i want my veladoras
and my San Martin, my yerbas
y mis plantas
y mis canarios, my God
why did my sons and daughters
and grandchildren do this to me?
and what shall I do now . . . ?
the open mouth, half asleep white trensas
as but to whom
is a better question yet?
the food tastes not like
my tasty tortillas y caldito
and mis atoles,
the TV in color is fine
but mi novela, what happened
to my novela on the Mexican channel?
and what shall I do now . . . ?
asks the woman from her bed
now that I cannot do anything,
wait for death to tie the string.

abelardo

C.A.T.

The elderly, the handicapped, and many others soon may be able to receive help and training without leaving their homes.

Cable Television:

Tomorrow's Service Delivery System

BENNY L. KASS. One day soon, in your own community, you may switch on your television set to see how well your staff is delivering information:

—to the community's aged population, to help them work out diet problems and menu planning and to help end their sense of isolation;

—to young people who have become habituated to drugs and need direct and truthful information on drug abuse and its elimination;

—to women operating family day care programs or parents who are providing foster care, bringing them up to date on new research information, new ideas for play or for helping children grow, or simply to give them the encouragement of their public servants;

—and to the area's unemployed, helping them understand the local job market, advising them on how to succeed in job interviews, or reminding them of their unemployment benefits and responsibilities.

All these—plus a lot more—are or soon will be possible through the communications medium known as Cable Television, or CATV (Community Antenna Television).

You may be familiar with CATV right now. There are about 2,500 operating cable systems presently in the United States, serving about 5.3 million homes or approximately 18 million viewers. It is estimated that by 1980, a total of 30 million homes will be connected to the cable, and that by the end of the century, practically all television, local and national, will be provided by cable.

Cable television was first introduced in remote, mountainous areas where over-the-air television reception was poor. About 20 years ago, in the mountains of Pennsylvania and Oregon, private entrepreneurs put master antennas on mountain tops to feed TV signals to subscribers in the valley below.

Coaxial cable was strung on poles from the antenna tower down into town; individual homes were connected to this main cable. Subscribers generally paid a one-time installation fee and a monthly service fee of $5 to $10 for the privilege of receiving the regular television programs via interference-free cable.

Wiring up a community can be done as the telephone company has done, by stringing wires on poles or running them through conduits underground, house-by-house. The original signal comes to a master antenna (known as the "head end" in the industry) or from local studios and is then distributed by cable throughout the market area, street-by-street and house-by-house. In the homes, viewers can select programming from channels 2-13 or, with adapters, from as many as 40 channels.

At first, CATV was only used to improve the quality of the television reception and to import distant TV signals to the local community. But cable has grown and developed in the past 20 years. We no longer talk about receiving better TV signals from distant locations.

Indeed, as Chairman Dean Burch of the Federal Commission wrote in a letter to Congress, on August 5, 1971, CATV is a powerful force for "improving the nation's communications systems — providing additional diversity of programming, serving as a communications outlet for many who previously have had little or no chance of ownership of or access to the television broadcast system, and creating the potential for a host of new communications services."

At a seminar recently sponsored by Publi-Cable — a public interest consortium of individuals concerned with the public development of CATV — some new services and potential uses were suggested just for community purposes alone: community forums, homemaker aid, job openings, art exhibits, library network, aging services, drama groups, local music groups, electronic voting, opinion polling, medical uses, transpor-

tation schedules, language instruction, and school sporting events.

In 1968, partly as a result of the need for a comprehensive analysis of the future of cable and partly due to pressure from the over-the-air broadcasters, the

Federal Communications Commission placed a freeze on the development of new cable systems.

Not until February 3, 1972, did the freeze end. The FCC then issued a lengthy document outlining new rules for cable television. While these rules are quite complex, a number of items must be highlighted.

1. All new systems in the top 100 television markets must have a *minimum channel capacity of 20 channels*. They must also have the capacity for return communication on at least a non-voice basis. According to the FCC, "two-way communication, even rudimentary in nature, can be useful in a number of ways — for surveys, marketing services, burglar alarm devices, and educational feedback, to name a few."

2. There must be at least *one "non-broadcast" channel for every "broadcast" channel*. A "broadcast channel" carries regular television programs, as currently transmitted by commercial networks and stations. But the FCC has stated that "cable television offers the technological and economic potential of an economy of abundance."

Accordingly, the FCC ruled that in order for cable television to realize some of its "potential within a national communications structure," at least one *non*-broadcast channel must be available for every broadcast channel in operation by the cable system. Simply piping in the programming already available from over-the-air broadcasters was not enough. Although the FCC was not willing to require a minimum channel capacity for every cable system throughout the country, as they had indicated earlier, the Commissioners did say that in the top 100 markets "a 20-channel capacity (actual or potential) is the minimum consistent with the public interest."

3. *There must be access to and use of non-broadcast channels*. The question of access and use is perhaps the most important public interest issue presently facing the development of cable television. Indeed, the FCC recognized this and said, in the promulgation of its new rules, "...It is therefore appropriate that the fundamental goals of a national communications structure be furthered by cable — the opening of new outlets for local expression, the promotion of diversity in television programming, the advancement of educational and instructional television, and increased information services of local governments. Accordingly, cable television systems will have to provide *one dedicated, noncommercial public access channel* available without charge at all times on a first-come, first-served nondiscriminatory basis and, without charge during a developmental period, *one channel for educational use* and *another channel for local government use*." (Italics are added.)

Public Access Channel: In effect, this is a "soap-box channel' whereby virtually anyone from the community with something to say will be permitted to have access to the cable's audience. The Federal Communications Commission has long held the view that CATV "has the potential to be a vehicle to much-needed community expression." According to the Commission, when it established the public access requirement, "We believe there is increasing need for channels for community expression, and the steps we are taking are designed to serve that need. The public access channel will offer a practical opportunity to participate in community dialogue through a mass medium."

Educational Access Channel: Here, too, the Commission expressed its intention to encourage innovation in the educational uses of television. Thus, local educational authorities are to have access to one designated channel for instructional programming and other educational purposes. Such use shall be without charge for the first five years. It was the FCC's belief that "The potential uses of the educational channel are varied. An important benefit promises to be greater community involvement in school affairs. It is apparent, for instance, that combined with two-way capability, the quality of instructional programming can be greatly enhanced. Similarly, some envision significant advances in the educational field by the linking of computers to cable systems with two-way capacity."

Governmental Access Channel: The FCC required that one channel be dedi-

cated for local government access. Its main purpose was to give maximum latitude for use by local governments. The suggestions for use range across a broad spectrum and include such ideas as traffic control, fire detection, civil defense, transportation schedules, and hospital and health care.

In its basic position, paper, Public-Cable set the tone for the public interest ramifications of cable communications:

"Publi-Cable believes that cable communications is or will become a vital element of our society in the future. It has the potential to change people's lives through better education, better jobs, and better lines of communication. Cable is not a luxury. In fact, it has already become a necessity in many parts of our country for many of our people. It seems to us that the issues set forth are not just about cable television, but instead are concerned with the future of America as it is influenced by our system of communications."

Indeed, as suggested earlier, even the FCC reached the conclusion that "cable television is an emerging technology that promises a communications revolution."

Our concern today is to develop cable to its fullest potential. While there is considerable experimentation in some areas — such as weather and meteorological services, banking and currency, pay TV, and data collection – there has been little experimentation with cable in the areas of social service and community development. But what has already been done is worth looking at and clearly shows the dramatic potential of cable communications.

Programs for the Deaf. The Deafness Research Training Institute is a Federally-funded rehabilitation center affiliated with New York University. It has recently developed a series of programs including a news service, early morning weather and transportation reports, public affairs discussions, and entertainment features. Conventional camera angles could not capture sign language, since the speaker must be visible full-face from the waist up. Accordingly, the Institute spent considerable time working out all the details, including positioning the interpreter for non-signing participants. Today, it is even possible to superimpose sign-language interpreters next to the regular speaker; hence, such programs as news reports and talk shows are now accessible to the deaf.

For the elderly. The Alternate Media Center works out of New York City and is perhaps the largest consumer of public access time on the New York cable systems. Productions have included tapings of housing protests by a tenants' cooperative, an Indian Rights march, and a neighborhood organizational campaign to get a new stoplight. Working with elderly people "on location" in New York, the Center prepared a series of tapes designed to stimulate the elderly

by presenting new ways of coping with life in the City. The format included discussions with old people in their homes and in their centers, shots of their activities and hobbies, and occasional service messages.

For the consumer. Working with Consumer's Union, the Center for Analysis of Public Issues for the Fund for the City of New York produced a half-hour program on the problem of flammable children's clothing. The program included a demonstration of the manner in which children's nightwear will burn; the manufacturers, retailers, and labels of the flaming garments were identified by name.

For the Unemployed. Cable television Channel 3 of Colorado Springs, Colorado, in cooperation with the Colorado State Department of Employment, sponsors a program every Tuesday at 10 a.m. listing jobs available in the Colorado Springs area, along with salary, requirements, and background information pertinent to each position. The half-hour show also features an interview with a guest who is an expert in some area of employment or employment training.

Obviously, there have been numerous other experiments. The three listed above merely highlight what can already be done with limited resources and with local talent.

Now that the FCC has issued new rules, however, there will be an immediate need for a wide range of programs to fill the dedicated channels. Cable operators will no doubt welcome suggestions for local programming.

A list is – or can be – literally as long as your imagination can take it. Cable, as has been indicated, is on the verge of creating a revolution. Perhaps it is more accurate to state that cable *itself* is the revolution. What is most important, however, can best be summed up in the words of the Sloan Commission's recent report entitled *On the Cable: The Television of Abundance:*

"Cable television today is at a stage where the general exercise of choice is still possible. If for no better reason than that there is a history of government regulation in the field of television, it remains possible by government action to prohibit it, to permit it, or to promote it almost by fiat. Citizens may still take a hand in shaping cable television's growth and institutions in a fashion that will bend it to society's will and society's best intentions. It is not as yet encumbered by massive vested interests, although that day may be no longer remote. It is not as yet so fixed a part of the national scene, as for example conventional television is, that it appears almost quixotic to attempt to redirect its energies. There is, in short, still time."

But not too much.

Mr. Kass is a member of the Steering Committee of the FCC's Federal-State/Local Advisory Committee on Community Antenna (Cable) Television.

CAREER OPPORTUNITIES

Adult and Aging Programs

FIELD CONSULTANT, ADULT SERVICES. Professional, Supervisory and consultation work in public welfare. Master's degree with 4 years of experience or 2 years in supervision, or a Bachelor's degree and 7 years of experience. $10,495—$13,022. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

CHIEF, BUREAU OF ADULT SERVICES. Plan a complete social service program for adults, including recipients of Old Age Assistance, Aid to Needy Blind, Aid to Permanently and Totally Disabled and Medical Assistance. Master's degree and 5 years of experience with 2 years in supervision. $12,144—$15,038. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

SOCIAL WORK SUPERVISOR (ADULT SERVICES). MSW and 1 year of experience. $11,124-$14,340. Can appoint above min. depending on experience. Write: Marathon Co. Dept. of Soc. Svc., 302 Grand Ave., Wausau, Wisc. 54401.

FIELD REPRESENTATIVE ON AGING. To develop and carry out community programs in State Office on Aging. Bachelor's degree in public administration, psychology, personnel management, or related field, and 2 years of experience in public or private personnel, public health, or related field. $593-$842. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

WELFARE SERVICES SPECIALIST. Adult Services Program. MSW and 1-1/2 years of experience. Additional experience may substitute for MSW on 2 for 1 basis. $9,600-$13,128. Write: Recruitment & Placement Sup'r, Dept. of Welfare & Institutions, Per. Sec., 429 S. Belvidere St., Richmond, Va. 23220.

SPECIALIST IN AGING I. To collect and communicate information about status of senior citizens; to train and supervise staff. Master's degree; or bachelor's and 1-2 years of experience in related field; or equivalent experience and training. $9,612. Write: Dir., Sr. Central, Mayor's Office for Sr. Citizens, 223, N. Michigan Ave., Chicago, Ill. 60601

SPECIALIST IN AGING II. To administer field program. Master's degree and 2-3 years of experience or bachelor's degree and 3-5 years of experience. $11,700. Write: Dir., Sr. Central, Mayor's Office for Sr. Citizens, 223 N. Michigan Ave., Chicago, Ill. 60601.

CLINICAL PSYCHOLOGIST Doctor's degree in psychology $1,062-$1,497. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

Mental Health

PSYCHOLOGY DIRECTOR. Doctor's degree in psychology and 4 years of postdoctoral experience in clinical psychology. $1,226-$1,729. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PSYCHIATRIST I. Medical degree, completion of approved internship, and 1 year of approved psychiatric residency. $1,777-$2,443. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PSYCHOLOGIST II. Master's degree in psychology and 1 year of experience. $787-$1,088. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PSYCHIATRIST II. Minimum requirements for Psychiatrist I, and 3 years of experience. $2,084-$2,667. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

CLINICAL PSYCHOLOGIST. Consultant to social service staff; administers and interprets psychological examination; participates in the monitoring and assessing of social service purchases under Title IV of the Social Security Act. $10,980—$15,660. Write: Personnel Director, St. Louis County Welfare Dept., 422 West Third St., Duluth, Minn. 55806.

Manpower Services

RESEARCH AND STATISTICS SPECIALIST. Master's degree in social science or related field and 2 years of responsible research experience, including the planning and conduct of research activities. $13,728. Write: Coordinator, Div. of Admin. on Aging, Dept. of Mental Health & MR, Room 1105, Ohio Depts. Bldg., Columbus, Ohio 43215.

DIRECTOR OF RESEARCH AND EVALUATION. Master's degree in behavioral sciences; Ph.D. preferred. Experience in survey research and statistics; experience in evaluation of social action programs desirable. $16,000—$20,000. Write: Correctional Manpower Services Project, 203 North Wabash Ave., Suite 2210, Chicago, Ill. 60601.

SYSTEMS ANALYST. To develop and operate a system of information storage and retrieval. Master's degree and 4 or more years of experience. $15,000. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR OF PLANNING, EVALUATION AND RESEARCH. (Health Care) Master's, Doctorate, or Medical degree preferred; 2 years of experience relating to health care systems. $14,000—$24,000. Write: Vanderbilt University Professional Recruitment, 110 Baker Building, 110-21st Ave., So., Nashville, Tenn. 37203.

MANPOWER PLANNING SPECIALIST. Master's degree in planning, business administration, industrial engineering, or social sciences desirable. Ability to write well required. $15,000—$18,000. Write: Correctional Manpower Services Project, 203 North Wabash Ave., Suite 2210, Chicago, Ill. 60601.

Health Services

EDITORIAL RESEARCH ASSOCIATE. To review literature and research in field of Maternal and Child Health and to report and evaluate MCH projects under study. Experience and education in health sciences, journalistic ability, and editorial experience in field of health. $17,000. Write: Helen M. Wallace, MD, U. of Cal. School of Public Health, 513 Earl Warren Hall, Berkeley, Calif. 94720.

PUBLIC HEALTH EDUCATOR. To direct comprehensive health education program. Master's degree in public health education, and 3 years of experience. $995-$1,250. Appointment at a higher grade permitted if candidate's qualifications exceed the minimum. Write: Merit System, 4th Floor, Centennial Office Bldg., 658 Cedar St., St. Paul, Minn. 55155.

NURSING CONSULTANT SUPERVISOR. Bachelor's degree in nursing and 3 years of experience in public health nursing or related field, including 1 year in supervision; or graduation from accredited school of nursing and 4 years in public health nursing, with 1 year in supervision. $821-$1,164. Write: Merit System Coun-

cil, 1910 W. 7th St., Little Rock, Ark. 72202.

PUBLIC HEALTH PHYSICIAN II. Assist in developing chronic disease programs and in regional program development. Medical degree and completion of internship in an approved hospital; Pa. license and 4 years of experience in the field of public health. $25,115—$29,079. Write: Director, Division of Chronic Diseases, Pa. Dept. of Health, P.O. Box 90 Harrisburg, Pa. 17120.

PUBLIC HEALTH NURSE CONSULTANT. Consult in specialized nursing, maternal and child health, communicable disease control, and crippled children. Master's degree in Public Health and 4 years of experience, 2 years in an advisory capacity. $8,778—$10,863. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

Nutrition

SUPERVISING DIETITIANS. Minimum qualifications for Dietitians plus additional 2 years of experience; or a master's degree and completion of an approved dietetic internship may be substituted for 1 year of experience. $9,814—$11,894. Write: State Dept. of Civ. Serv., State Off. Bldg., Campus, Albany, NY 12226.

DIETITIANS. Bachelor's degree in dietetics or related field, or in home economics with major in nutrition, and 1 year of experience in hospital or therapeutic dietetic work; or completion of approved postgraduate hospital dietetic internship; or master's degree in dietetics or nutrition. $8,648-$10,104. Write: State Dept. of Civ. Serv., State Off. Bldg. Campus, Albany, NY 12226.

DIETITIAN TRAINEES. Bachelor's degree with major in dietetics or related field, or home economics. $8,169. Write: State Dept. of Civ. Serv., State Off. Bldg., Campus, Albany, NY 12226.

NUTRITION SPECIALIST. To direct a state-wide program in nutrition for the elderly. Bachelor's degree in food/nutrition plus Master's or MPH in nutrition. Completion of a dietetic internship or its equivalent. $15,787. Write: Coordinator, Division of Administration on Aging, Dept. of Mental Health and Mental Retardation, 1105 Ohio Dept. Bldg., Columbus, Ohio. 43215.

Faculty Appointments

PROGRAM SPECIALIST, REHABILITATION OPERATIONS MANAGEMENT OR PRODUCTION. Plan, organize, and teach in training seminars for rehab personnel; may teach 1 undergraduate class. Some travel. Master's degree in Rehab. Management, Ind. Ed. or Ind. Engineering and 5 years of experience. Salary according to qualifications. Write: Project Dir., Region III Training Program for Facility Pers., Jull Hall, U. of Maryland, College Park, Md. 20742.

SPEECH PATHOLOGIST. Direct and coordinate speech pathology, language development, teaching and research program. Ph.D. Salary open and competitive. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

PROJECT DIRECTOR. To coordinate health manpower study, conduct surveys and collect data. Master's or Ph.D. preferred but not essential; familiarity with survey methods, health manpower data sources. $15,000, some room for negotiation. Write: Director, Health Systems Res. Div., Box 210, Med. Sci. Bldg., U. of Florida, Gainesville, Fla. 32601.

ASSISTANT DIRECTOR. To develop and implement projects, do research, direct graduate students, and teach as required in" health systems. Ph.D. in operations research, engineering, business admin., or behavioral science with quantitative emphasis. Some experience in health systems analysis desirable. $18,000. Write: Dir., Health Systems Res. Div., Box 210, Med. Sci. Bldg., U. of Florida, Gainesville, Fla. 32601.

CORRECTIONS INSTRUCTOR. To teach undergraduate and graduate classes in corrections, probation and parole. Doctorate degree and 3 years of experience in a correctional agency. Salary is negotiable, depending on experience. Write: Director, Corrections Program, Chicago State U., 500 North Pulaski Rd. Chicago, Ill. 60624.

CORRECTION PROGRAM FIELD COORDINATOR. Master's degree with specific training in corrections or related field and 3 years of experience in prevention, probation, prison or parole (either juvenile or adult). $14,000. Write: Associate Professor, School of Social Work, Western Michigan University, Kalamazoo, Mich. 49001.

ASSOC. PROJECT DIRECTOR. For rehabilitation programs. Doctoral degree in rehab. admin. or closely related field and broad experience in rehabilitation. Salary dependent on qualifications. Write: Project Dir., Region III Training Program for Facility Pers., Jull Hall, U. of Maryland, College Park, Md. 20742.

Social Work Supervision

SOCIAL SERVICES DIRECTOR. Master's degree in public, business, health or welfare administration or social work, and 5 years responsible administrative experience, or an equivalent combination of training and experience. $17,052-$22,470. Write: Dane Co. Pers. Off., Room 102, City-Co. Bldg., Madison, Wis. 53709. Closing date 10/16/72.

CHIEF (3): BUREAU OF LICENSING & STANDARDS; BUREAU OF CONSUMER SERVICES; BUREAU OF COMMUNITY SERVICES. Bachelor's degree and 9 years of experience (5 in supervision), or 12 years (5 in supervision), or equivalent combination of training and experience. $15,180. Write: Dept. of Pub. Welfare, Div. of Emp. Mgt. Rel. 408 E. Town St., Columbus, Ohio. 43215

LOCAL WELFARE DIRECTOR II MSW and 1 year of experience in social work. Additional experience may substitute for MSW on a year for year basis. $9,470—$15,315. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

FIELD CONSULTANT, CHILD AND FAMILY SERVICES. Professional, supervisory and consultation work in public welfare. Master's degree and 5 years of experience or a Bachelor's degree and 8 years of experience. $10,975—$13,596. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

SUPERVISOR, ASSISTANCE PAYMENTS. Master's degree in social science and 3 years of experience, or a Bachelor's degree and 6 years of experience. $9,531—$11,639. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

ASST. CHIEF, MEDICAL SOCIAL SERVICE. Master's degree in social work or a related field with 3 years of experience in social work, or 1 year in medical social work or medical care administration. $10,495—$13,022. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

ASST. SUPERVISOR, ASSISTANCE PAYMENTS. Administer money payment programs; assist in training and supervision of case technicians. Master's degree and 2 years of experience or Bachelor's degree and 5 years of experience. $8,778—$10,863. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

QUALITY CONTROL REVIEWER. To evaluate case records to determine compliance with existing policies and identify defective case activities. Bachelor's degree and 3 years of experience. $8,414—$10,390. Write: Dept. of Personnel, State House Annex, Concord, N.H. 03301.

SPEECH PATHOLOGIST. Direct and coordinate speech pathology, language development, teaching

and research program. Ph.D. Salary open and competitive. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

Medical Services

PHARMACIST II. Degree in pharmacy, license to practice in Florida, and 2 years of experience. $929-$1,290. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

NURSING DIRECTOR I. RN and 5 years of professional experience at supervisory or administrative level. $810-$1,122. Write: Dept. of Admin., Div. of Pers'l. and Retirement, Carlton Bldg., Tallahassee, Fla. 32304.

PHYSICAL THERAPIST (FIELD). Graduation from an approved school of physical therapy and licensed to practice in Va. $8,400—$10,992. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

Casework

CASEWORKER (PROTECTIVE SERVICES INTAKE). Intensive treatment of parents and children. MSW. No experience. $793. Write: Dir., Outagamie Co. Dept of Soc. Svc., Court House Annex, Appleton, Wis. 54991.

SOCIAL WORKER. MSW or related field (not rehabilitation counseling). $11,046 (GS-9). Write: Dir., Alcohol & Drug Off., Hq. Ft. Hamilton, Brooklyn, NY 11252.

SOCIAL WORKER II. To work as Probation and Parole Agent or as Counselor in Correctional Institution. MSW. $878-$973 start. Write: Supervisor of Recruitment, Div. of Corrections, Box 669, Madison, Wis. 53701.

MEDICAL SOCIAL WORKER—A. Master's degree. $8,040—$8,784. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

MEDICAL SOCIAL WORKER—B. Master's degree and 2 years of experience. $9,168—$12,000. Write: Merit System Supervisor, 300 State Finance Bldg., Richmond, Va. 23219.

MEDICAL SOCIAL WORK—C. Master's degree and 3 years of experience. $10,032—$12,528. Write: Merit System Supervisor, 300 State Finance Bldg. Richmond, Va. 23219.

Mail your agency's classified listings to Editor, HUMAN NEEDS, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or nongovernmental listings accepted. There is no charge or fee of any kind for this service.

CASEWORKER I. Bachelor's degree and knowledge of principles and techniques of social case work. $508-$719. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

PUBLIC HEALTH SOCIAL WORKER. MSW and 2 years of experience, including supervised social case work and clinical experience. Driver's license necessary. $11,929—$12,412 (Upstate) $12,129—$12,612 (Metropolitan Area). Write: Director, Public Health Social Work, New York State Dept. of Health, 845 Central Ave., Albany, N.Y. 12206.

CASEWORKER II. Bachelor's degree in sociology or realted field; 1 year of graduate study toward MSW or 1 year of experience in social work. $549-$779. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

SOCIAL WORKER II. Bachelor's degree and 1 year of experience. $9,023-$10,663. Write: Dept. of Civil Svc., Arnold Constable Bldg., Front & Montgomery Sts., Trenton, NJ 08625.

SOCIAL WORKER. Bachelor's degree and 3 years of experience; 3 years as County Director (as certified by Commr. of Public Welfare) may be substituted for college. $593-$842. Write: Merit System Council, 1910 W. 7th St., Little Rock, Ark. 72202.

SOCIAL SERVICE WORKER IV. Master's degree. $8,712—$11,016. Write: County Director II, Benson County Welfare Board, Minnewaukan, N. Dak. 58351.

SOCIAL WORKER. To direct an Alcoholic Treatment Addiction Center. MSW. $10,600. Write: Employment Manager, Kings County Hospital Center, 451 Clarkson Ave., Bldg. 'D', Brooklyn, N.Y. 11203.

Rehabilitation

REHABILITATION COUNSELOR. In facility setting, primarily for mentally retarded. Master's degree preferred in rehab. counseling or related field; or bachelor's degree. Experience helpful but not required. $8,000 (B.A.); $9,200 (M.A.). Write: Sup'r, N. Cent. Rehab. Ctr., 746 14th Av. N., Fort Dodge, Iowa 50501.

ASST. WORKSHOP DIRECTOR (Rehabilitation). Bachelor's degree preferred. $8,500 depending on qualifications. Write: Director, Randolph County Sheltered Workshop, P.O. Box 151, Red Bud, Ill. 62278.

VOCATIONAL EVALUATOR II. Master's degree in vocational rehabilitation, vocational evaluation, or Bachelor's degree and 2 years of experience in vocational evaluation, rehabilitation, tests and measurements or other related field. $9,408—$11,718. Write: Vocational Evaluation Supervisor, Vocational Evaluation Unit, 1620 E. Polk St., Phoenix, Ariz. 85006.

PSYCHOLOGIST. Performs work-oriented psychological appraisals for a multidisability vocational evaluation and work adjustment program. Master's degree in psychology or rehabilitation; must be able to qualify for certification as Psychological Associate in Texas. Previous rehabilitation experience and bilingual (Spanish) preferred but not required, $12,000. Write: Program Administrator, Harlingen Vocational Evaluation Center, 300 Camellia, Industrial Airpark, Harlingen, Tex. 78550.

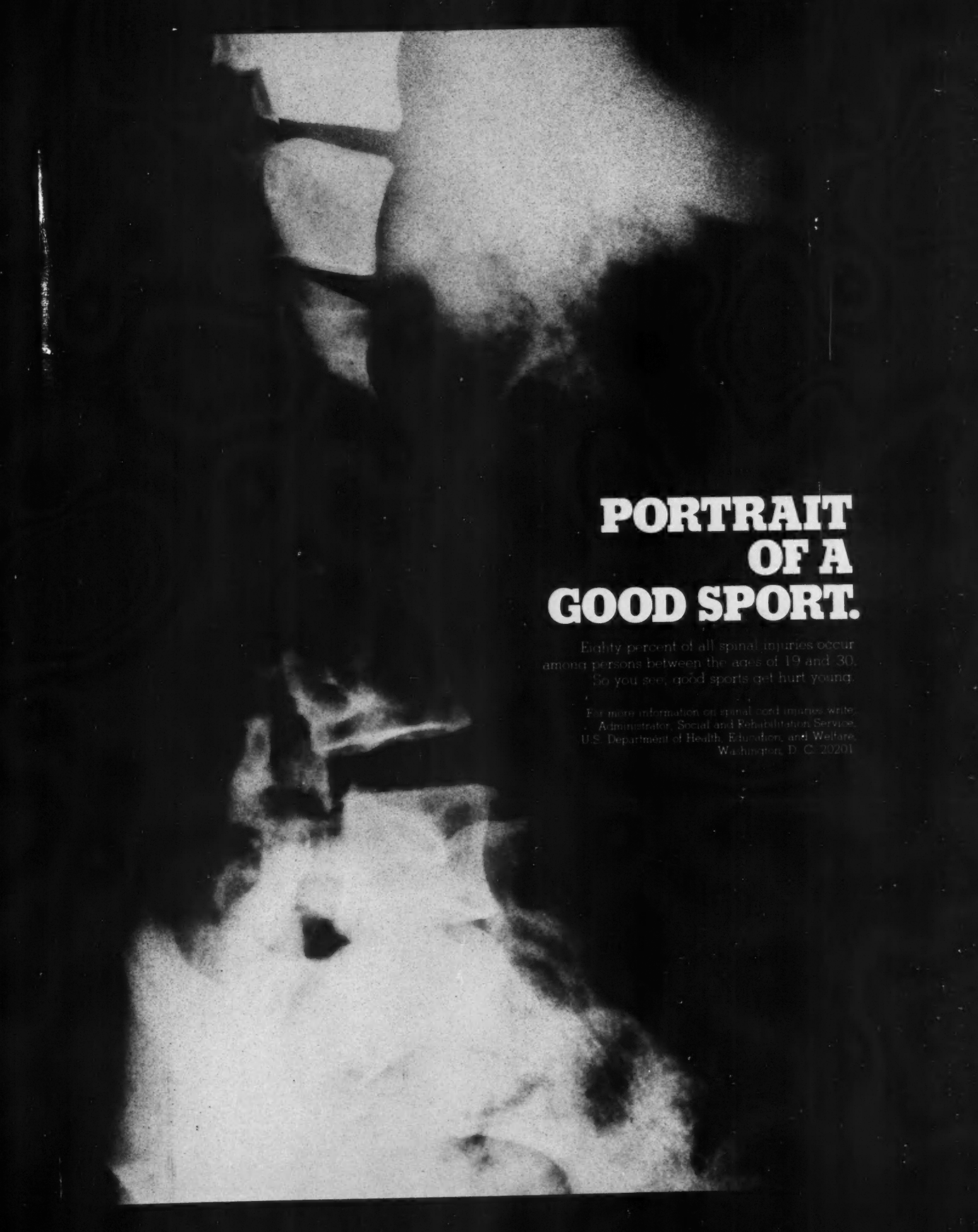
Children and Youth

NURSE. Direct and coordinate teaching and research program in nursing for children with handicaps. Master's degree, prefer doctorate, with background in public health or programs for children. Salary open and competitive. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

COORDINATOR FOR CONTINUING EDUCATION AND IN-SERVICE TRAINING. To provide the major staff resource for the Institute's in-service training and education programs, including technical assistance to community services. Master's degree and experience in developing continuing education programs. Salary dependent upon training and experience. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR, SOCIAL WORK TRAINING. Direct and coordinate teaching and research programs in social work for children with handicaps. Ph.D. or D.S.W. with interest in developmental disabilities and experience in community organization. Salary open. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.

DIRECTOR, PHYSICAL THERAPY PROGRAM. Master's degree with certification in neurodeveiopmental (Bobath) treatment; experience in children's programs. $12,000—$13,500. Write: Director, Meyer Children's Rehabilitation Institute, (U. of Neb.), 444 So. 44th St., Omaha, Neb. 68131.



PORTRAIT OF A GOOD SPORT.

Eighty percent of all spinal injuries occur among persons between the ages of 19 and 30. So you see, good sports get hurt young.

For more information on spinal cord injuries write, Administrator, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D. C. 20201

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